STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	C 04/21/2009

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HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a Medicare complaint investigation which was completed on 4/21/09. Seven records were sampled. The survey was conducted in accordance with 42 CFR Chapter IV Part 483 Requirements for States and Long Term Care Facilities. The following complaint was investigated: Complaint #NV21850 - Substantiated (F Tags 157, 309, 325, 441) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficienices were identified.	F 000	This Plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Hearthstone of Northern Nevada agrees with the allegations and citations listed on the statement of deficiencies. Hearthstone maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Hearthstone's written credible allegation of compliance. By submitting this plan of correction, Hearthstone does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Hearthstone reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.	
F 157 SS=G	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse	F 157		5-22-09

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LAS VEGAS, NEVADA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Molly Larson — 5/26/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the physician of changes in condition in a timely manner for 2 of 7 sampled residents (#2, #3). Findings include: Resident #2 Resident #2 was admitted to the facility on 1/15/09, with diagnoses including end stage renal disease, failure to thrive, coronary atherosclerosis, congestive heart failure, atrial fibrillation, anemia, and hypothyroidism. The resident's legal representative had been performing peritoneal dialysis for the resident in the community for six years, without the resident contracting an infection.	F 157	**F 157 Notification of Changes of Condition** Resident # 1, 2, and 3 have been discharged from the facility. Residents residing in the facility have the potential to be affected. The measures in place are as follows: Re-education of the nursing staff to reinforce what constitutes a change in condition was completed by the DON/designee. The change of condition report will be readily available to charge nurses and be attached to the 24 hour report. Physician, Physician's Assistant, Nurse Practitioner and family will be promptly notified by the charge nurse of a change in condition on a shift by shift basis.	5-22-09

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F 157	Continued From page 2 Record review revealed a Minimum Data Set resident assessment for Resident #2: Section B., 4. Cognitive skills for daily decision making, dated 1/22/09, that showed that the resident had been independent in decision making with "decisions being consistent/reasonable." Record review revealed a weekly nursing summary dated 1/22/09, with the following boxes checked: "Alert, memory recall - current season, staff names/faces, that he was in a nursing home; decision making - independent. A weekly nursing summary dated 1/28/09, read: Alert, memory recall - staff names/ faces, that he is in a nursing home; decision making - independent." Record review revealed a physician's progress note dated 1/19/09 that read: "Abdomen: normal, peritoneal catheter." Record review revealed that Resident #2 had been transferred to an acute care facility on 3/7/09, for coughing and hypoxia. On 4/6/09 at 10:30 AM, Resident #2's son-in-law was interviewed and reported that a nurse from the facility contacted him on 3/6/09 at 8:00 AM, to notify him that the resident was coughing and refusing to take his medications. The son-in-law reported that the resident had become progressively worse overnight, with an oxygen saturation of 74% and the nurse had called again in the morning on 3/7/09. He reported that the nurse had stated to him that the resident's condition had deteriorated and that the nurse had asked him if he would like her to send him to the hospital. The resident's son-in-law then reported that he directed the nurse to call the nephrologist	F 157	Nurses will be required to complete walking rounds with the incoming replacement nurse. This will be monitored on a daily basis for change in condition by the 24 hour report and discussed daily in stand-up meeting. Monthly follow up will be monitored in Performance Improvement Committee meetings. Ultimate RP → by DON per interview with Molly Larson cadmin on 6/11/09 - [signature] RN	5-22-09

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F 157	Continued From page 3 that followed the resident for treatment of his renal failure. He then reported that the nurse was not aware that the resident had a nephrologist involved with the resident's care. The nurse then agreed to call the nephrologist. The resident's son-in-law further reported that the nurse called him to report that she was directed by the nephrologist to send the resident to an acute care facility emergency department. The nurse then reportedly called a dialysis nurse consultant to determine whether or not to send the resident to the hospital. The resident's son-in-law reported that the nurse then called back to ask what hospital to send the resident to, and the son-in-law reported that he told her to send the resident to the closest hospital. The resident reportedly passed away on 3/11/09. Record review revealed a death certificate that reported that the resident had expired and that the cause of death was peritonitis. Review of Resident #2's medical record revealed entries made into the nurse's notes that contained the following: 2/25/09 - the psychiatrist did a consult with the resident and documented that the resident was "underhydrated?" 2/26/09 - "Patient continues to not eat takes some fluids... Increased apical rate, abdominal distension..." 2/27/09 - "the resident had an elevated temperature" 3/6/09 - "Resident agitated; resident coughing, chest x-ray ordered to rule out pneumonia; weight loss 31 pounds" 3/7/09 - "Resident agitated, yelling for help; alert and oriented to self, skin pale; breathing labored and oxygen saturation 74%; skin ash color with labored breathing; sent to emergency room for	F 157		

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F 157	Continued From page 4 evaluation." No evidence was found that the nursing staff had contacted the physician related to a change in Resident #2's condition prior to 3/7/09. No evidence was found that the resident's primary physician had been aware of the psychiatrist's impression on 2/25/09. Resident #3 Resident #3 was admitted to the facility on 3/18/09, with diagnoses including end-stage renal disease requiring peritoneal dialysis, diabetes mellitus and peripheral vascular disease. The resident was dependent for all peritoneal dialysis needs. Record review revealed a document titled "Nursing Assessment" that was completed upon Resident #3's admission on 3/18/09 that read: "Section 3. Vital Signs: temperature - 98.0 Fahrenheit Section 8. Physical Assessment: A. Neuro/Cognitive: independent in decision making with "decisions being consistent/reasonable." E. Pain: denies pain on admission J. Gastrointestinal: no problems documented" Record review revealed that Resident #3 had been transferred to an acute care facility on 4/4/09, with a temperature of 100.3 Fahrenheit. Record review revealed the following nurse's notes entries: 3/23/09 - "Has disorientation at times." 3/24/09 - "Resident very needy, on the call light every 10 minutes."	F 157		

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F 157	Continued From page 5 3/25/09 - "Keeps on moaning, complains of shoulder pain." 3/28/09 - "Medicated for pain in left shoulder." 3/31/09 - "Resident difficult today. Not compliant. Found medications in his bed. Restless early shift. Calling for help constantly. Dialysis machine keeps beeping." Record review revealed the following: 3/24/09 night shift: temperature - 99.4 Fahrenheit 3/26/09 night shift: temperature - 99.1 Fahrenheit 4/4/09 night shift: temperature - 99.1 Fahrenheit Record review revealed the following entries into the physical therapy weekly summary: 3/20/09 - 3/26/09: "Patient has been ill intermittently...but puts effort towards his exercises ... throughout the day and tries his best without trying to regurgitate onto his caregivers." 3/27/09 - 4/2/09: "Actively participated in three of five treatments due to ... bilateral shoulder pain." Record review revealed no evidence that the physician had been made aware of Resident #3's condition changes prior to the day that the resident was transferred to the acute care facility. The Director of Nursing (DON) was interviewed on 4/9/09 at 11:20 AM, and reported that signs and symptoms to look for that may be indicative of peritonitis included: Distension or tenderness of the abdomen, nausea or vomiting, diarrhea, shoulder pain, elevated temperature, anxiety, change in level of consciousness, confusion, or draining of cloudy dialysate. Record review of a physician's progress note dated 3/26/09, revealed: "had vomiting after therapy."	F 157		

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F 157	Continued From page 6 The DON was interviewed on 4/9/09 at 11:20 AM, and reported that Resident #3 had been admitted to the acute care facility on 4/4/09, with a diagnosis of peritonitis. Review of Resident #3's acute care record revealed that on 4/5/09, the emergency department physician recorded: "Assessment: 1. Sepsis, source peritonitis versus health care associated pneumonia. Emergency Department Course: White blood cell count 14,000. X-ray was clear for pneumonia." Record review revealed that Resident #3 was still an inpatient at the acute care facility on 4/20/09. Complaint #21850	F 157		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of policy and procedure and industry standards, the facility failed to provide necessary care and services related to peritoneal dialysis for 2 of 7 sampled residents (#2, #3).	F 309	**F 309 Quality of Care** Resident # 1 and # 2 have been discharged from the facility. Residents residing in the facility that receive peritoneal dialysis have the potential to be affected. The measures in place are as follows: Re-educated Nursing staff on the policy and procedure on peritoneal dialysis on 4/16/09 by Director of Education.	5-22-09

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F 309	Continued From page 7 Findings include: Resident #2 Resident #2 was admitted to the facility on 1/15/09, with diagnoses including end stage renal disease, failure to thrive, coronary atherosclerosis, congestive heart failure, atrial fibrillation, anemia, and hypothyroidism. The resident's legal representative had been performing peritoneal dialysis for the resident in the community for six years, without the resident contracting an infection. Record review revealed a Minimum Data Set resident assessment for Resident #2: Section B., 4. "Cognitive skills for daily decision making," dated 1/22/09, that showed that the resident had been independent in decision making with "decisions being consistent/reasonable." Record review revealed a weekly nursing summary dated 1/22/09, with the following boxes checked: "Alert, memory recall - current season, staff names/faces, that he is in a nursing home; decision making - independent." A weekly nursing summary dated 1/28/09, read: "Alert, memory recall - staff names/ faces, that he is in a nursing home; decision making - independent." Record review revealed a physician's progress note dated 1/19/09 that read: "Abdomen: normal, peritoneal catheter." Record review revealed that Resident #2 had been transferred to an acute care facility on 3/7/09, for coughing and hypoxia. On 4/6/09 at 10:30 AM, Resident #2's son-in-law	F 309	Licensed Nursing staff will have competency skills checklist on connecting and disconnecting CAPD residents from treatment and policy on appropriate method and time of using gloves by Director of Education/designee. Chart of a resident receiving peritoneal dialysis will be scrubbed by Director of Nursing/designee for completeness of documentation within 24 hours of admission and ongoing. Daily weights of residents on CAPD will be reported to the Director of Nursing/designee and dietician/designee to address weight changes per policy and procedures on weight management. In addition nephrologist and dialysis dietician will be notified for collaborative approach on weight management.	

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F 309	Continued From page 8 was interviewed and reported that a nurse from the facility contacted him on 3/6/09 at 8:00 AM, to notify him that the resident was coughing and refusing to take his medications. The son-in-law reported that the resident had become progressively worse overnight, with an oxygen saturation of 74% and the nurse had called again in the morning on 3/7/09. He reported that the nurse had stated to him that the resident's condition had deteriorated and that the nurse had asked him if he would like her to send him to the hospital. The resident's son-in-law then reported that he directed the nurse to call the nephrologist that follows the resident for treatment of his renal failure. He then reported that the nurse was not aware that the resident had a nephrologist involved with the resident's care. The nurse then agreed to call the nephrologist. The resident's son-in-law further reported that the nurse called him to report that she was directed by the nephrologist to send the resident to an acute care facility emergency department. The nurse then reportedly called a dialysis nurse consultant to determine whether or not to send the resident to the hospital. The resident's son-in-law reported that the nurse then called back to ask what hospital to send the resident to, and the son in law reported that he told her to send the resident to the closest hospital. The resident reportedly passed away on 3/11/09. Record review revealed a death certificate that reported that the resident had expired and that the cause of death was peritonitis. Review of Resident #2's medical record revealed entries made into the nurse's notes that contained the following: 2/25/09 - the psychiatrist did a consult with the resident and documented that the resident was	F 309	The Nursing Assessment Coordinator will be responsible to oversee that care plans reflect the care provided for each CAPD resident. Staff will be re-educated on proper hand washing techniques with return demonstration by Director of Education/designee by 5/22/09. Peritoneal residents care status will be reviewed in the monthly Quality of Care meeting and reported during monthly Performance Improvement meetings. The Director of Nursing or designee will monitor this process on an ongoing basis. - per molly Larson interview on 5/18/09, the date of future is 5/22/09	

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F 309	Continued From page 9 "underhydrated?" 2/26/09 - "Patient continues to not eat takes some fluids... Increased apical rate, abdominal distension..." 2/27/09 - "the resident had an elevated temperature" 3/6/09 - "Resident agitated; resident coughing, chest x-ray ordered to rule out pneumonia; weight loss 31 pounds" 3/7/09 - "Resident agitated, yelling for help; alert and oriented to self, skin pale; breathing labored and oxygen saturation 74%; skin ash color with labored breathing; sent to emergency room for evaluation." No evidence was found that the nursing staff had contacted the physician related to a change in Resident #2's condition prior to 3/7/09. No evidence was found that the resident's primary physician had been aware of the psychiatrist's impression on 2/25/09. Record review revealed a care plan for Resident #2 that was developed for outpatient dialysis therapy. The care plan revealed the following: "Goals: will not experience complications secondary to dialysis for 90 days. Approach: 1. Resident will be transported to dialysis center on treatment days. 2. Resident will be provided with take out meals if not in the facility at mealtimes. 3. Avoid taking blood pressures or giving injections over shunted arm. 5. After dialysis treatment observe resident for adverse reactions to treatment." Record review revealed that Resident #2 had no shunt, was not transported out, as his peritoneal	F 309		

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F 309	Continued From page 10 dialysis was performed at the facility. Resident #3 Resident #3 was admitted to the facility on 3/18/09, with diagnoses including end-stage renal disease requiring peritoneal dialysis, diabetes mellitus and peripheral vascular disease. The resident was dependent for all peritoneal dialysis needs. Record review revealed a document titled "Nursing Assessment" that was completed upon Resident #3's admission on 3/18/09 that read: "Section 3. Vital Signs: temperature - 98.0 Fahrenheit Section 8. Physical Assessment: A. Neuro/Cognitive: independent in decision making with "decisions being consistent/reasonable." E. Pain: denies pain on admission J. Gastrointestinal: no problems documented" Record review revealed that Resident #3 had been transferred to an acute care facility on 4/4/09, with a temperature of 100.3 Fahrenheit. Record review revealed the following nurse's notes entries: 3/23/09 - "Has disorientation at times." 3/24/09 - "Resident very needy, on the call light every 10 minutes." 3/25/09 - "Keeps on moaning, complains of shoulder pain." 3/28/09 - "Medicated for pain in left shoulder." 3/31/09 - "Resident difficult today. Not compliant. Found medications in his bed. Restless early shift. Calling for help constantly. Dialysis machine keeps beeping."	F 309		

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F 309	Continued From page 11 Record review revealed the following: 3/24/09 night shift: temperature - 99.4 Fahrenheit 3/26/09 night shift: temperature - 99.1 Fahrenheit 4/4/09 night shift: temperature - 99.1 Fahrenheit Record review revealed the following entries into the physical therapy weekly summary: 3/20/09 - 3/26/09: "Patient has been ill intermittently...but puts effort towards his exercises ... throughout the day and tries his best without trying to regurgitate onto his caregivers." 3/27/09 - 4/2/09: "Actively participated in three of five treatments due to ... bilateral shoulder pain." Record review revealed no evidence that the physician had been made aware of Resident #3's condition changes prior to the day that the resident was transferred to the acute care facility. The Director of Nursing (DON) was interviewed on 4/9/09 at 11:20 AM, and reported that signs and symptoms to look for that may be indicative of peritonitis include: Distension or tenderness of the abdomen, nausea or vomiting, diarrhea, shoulder pain, elevated temperature, anxiety, change in level of consciousness, confusion, or draining of cloudy dialysate. Record review of a physician's progress note dated 3/26/09, revealed: "had vomiting after therapy." The DON was interviewed on 4/9/09 at 11:20 AM, and reported that Resident #3 had been admitted to the acute care facility on 4/4/09, with a diagnosis of peritonitis. Review of Resident #3's acute care record	F 309		

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F 309	Continued From page 12 revealed that on 4/5/09, the emergency department physician recorded: "Assessment: 1. Sepsis, source peritonitis versus health care associated pneumonia. Emergency Department Course: White blood cell count 14,000. X-ray was clear for pneumonia." Record review revealed that Resident #3 was still an inpatient at the acute care facility on 4/20/09. The Staff Development Coordinator was interviewed on 4/9/09 at 11:00 AM, and reported that almost all of the registered nurses (RNs) had completed training related to peritoneal dialysis. She reported that the facility had a consultant from a local dialysis center come in and train the facility staff related to peritoneal dialysis. Review of the dialysis consultant's training outline revealed that he recommended that staff not wear gloves throughout the peritoneal dialysis procedures. On 4/9/09 at 11:40 AM, the dialysis consultant was interviewed, and reported that he does recommend that staff not wear gloves during the peritoneal dialysis procedures because the powder in the gloves is a common source of peritonitis. When asked if the procedures are to be performed using aseptic technique, he replied "no, it is a clean procedure." The DON reported that she performs the peritoneal dialysis procedures on week-days. She reported that she does not wear gloves while performing peritoneal dialysis procedures.	F 309		

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F 309	Continued From page 13 The Staff Development Coordinator was interviewed and reported that the nurses were instructed not to wear gloves because the powder inside of the gloves is a common cause of peritonitis. Record review revealed no evidence that staff were wearing gloves while performing peritoneal dialysis procedures. Review of the facility's policies and procedures revealed a policy and procedure dated 2004, titled: "Nursing Standards of practice, Subject: Dialysis, Peritoneal (CAPD) Standard: 1. The qualified nursing staff will provide care as ordered by a physician for patients/residents requiring peritoneal dialysis that allows them to maintain their highest practicable level of function and health. 2. The qualified nursing staff will follow the (corporate) guidelines. 3. The health care center will obtain the Resident Acknowledgement of Informed Consent Form #FFNP006 4. Refer to the Staff Development Standards of Practice: #24 Competency for Peritoneal Dialysis." "Description: Infection control practices and technique are essential to prevent the occurrence of peritonitis which often may prevent patients/residents from continuing to use peritoneal dialysis as a treatment modality. Staff who provide care must receive specialized training so they possess advanced skill levels	F 309		

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F 309	Continued From page 14 before providing peritoneal dialysis. Equipment: C. sterile and non-sterile gloves Practice Guidelines: 5. Assess A. Weight: Baseline is needed to determine fluid to be removed. Dialysis Exchange: C. Wash hands, don mask and non-sterile gloves. Both licensed nurse and patient/resident mask. N. Don sterile gloves." Review of a peer review article published by the Mid-Atlantic Renal Coalition dated 12/02, titled: "Preventing Bacterial Infections and Antimicrobial Resistance in Dialysis Patients," revealed the following: "Strategy 4: Prevention -The Centers for Disease Control and Prevention (CDC) recommends wearing gloves at all times when touching patients or dialysis equipment to prevent infections by contaminants too small to be seen with the naked eye." Complaint #21850	F 309		
			F 325	
F 325 SS=G	483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325	Resident # 1 and resident # 2 have been discharged **from** the facility. Residents residing in the facility have the potential to be affected.	

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F 325	Continued From page 15 nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review, interview, policy review, and review of industry standards the facility failed to ensure adequate interventions to prevent a significant weight loss for 2 of 7 sampled residents (#1, #2). Findings include: Resident #1 Resident #1 was admitted to the facility on 11/10/08, with diagnoses including ulcerations of the lower extremities, protein calorie malnutrition, depression, and Methicillin resistant staphylococcus aureus (MRSA) infection of lower extremity wound. Record review revealed that Resident #1 was 73 inches in height. Record review revealed that Resident #1's weight was checked on the following dates: 11/10/08 (admission): 192 pounds 11/11/09: 193 pounds 11/12/08: 193 pounds 11/19/08: 192 pounds 12/11/08: 133 pounds 12/17/08: 133 pounds 12/24/08: 138 pounds 1/1/09: 146 pounds 1/8/09: 138 pounds 1/21/09: 137 pounds	F 325	The measures in place are as follows: Registered Dietician will perform a nutritional evaluation of all residents admitted to the facility Weekly weight meetings will continue with review of all weight fluctuations and appropriate interventions will be implemented. Monitoring will occur in daily stand up meetings, weekly weight meetings, Quality of Care Meetings. Registered Dietician will follow facility policy and procedures and industry standards. Performance Improvement Committee will review and monitor monthly. Ultimate responsibility is assigned to Registered Dietitian per Molly Lorenzen 6/1/09	5-22-09

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F 325	Continued From page 16 2/1/09: 140 pounds Record review revealed that the resident's usual body weight was 190 pounds. Record review further revealed that the resident had lost 53 pounds, or 26.4% of his usual body weight over a 3 month period. Record review revealed a care plan for Resident #1 that was not dated. It listed a goal of "weight will stabilize at 190 pounds." Interventions included: "4 ounces of house supplement three times daily between meals, encourage intake of meals and offer alternate if (intake) less than 75%, offer snacks per protocol, ice cream with lunch and dinner, report weight change to physician, dietician, and family." The dietitian was interviewed on 4/9/09 at 11:30 AM, and reported that Resident #1 had stated to her that "he wanted to be at or around 190 pounds." She further reported that she did not get aggressive with the resident's nutritional care because she felt that the scale must have been inaccurate. She reported that she did not recommend that the scale be checked or calibrated. Resident #2 Resident #2 was admitted to the facility on 1/15/09 with diagnoses including end stage renal disease, failure to thrive, coronary atherosclerosis, congestive heart failure, atrial fibrillation, anemia, and hypothyroidism. The resident's legal representative had been performing peritoneal dialysis for the resident in the community for six years.	F 325		

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F 325	Continued From page 17 Record review revealed that Resident #2 was 68 inches in height. Record review revealed that Resident #2's weight was checked on the following dates: 1/16/09: 193 pounds 1/17/09: 190 pounds 1/18/09: 188 pounds 1/21/09: 189 pounds 1/23/09: 186 pounds 1/24/09: 182 pounds 1/25/09: 187 pounds 1/26/09: 185 pounds 1/27/09: 183 pounds 2/1/09: 181 pounds 2/2/08: 180.6 pounds 2/3/09: 173 pounds 2/4/09: 176 pounds 2/5/09: 177 pounds 2/6/09: 178 pounds 2/7/09: 175 pounds 2/11/09: 167 pounds 2/18/09: 168.3 pounds Record review of an entry into the nurse's note dated 3/6/09 revealed: "Resident's weight 159 weight loss of 31 pounds." Record review revealed that the resident's usual body weight was 190 pounds. Record review further revealed that the resident had lost 25 pounds, or 11.6% of his usual body weight over a 1 month period. 2/25/09 - The psychiatrist did a consult with Resident #2 and documented that the resident was "underhydrated?" No evidence was found that the resident's primary physician had been aware of the psychiatrist's impression.	F 325		

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F 325	Continued From page 18 Resident #2's legal representative was interviewed and reported that the resident did not have large weight fluctuations prior to admission to the facility. He reported that the resident's weight was checked frequently at home due to his renal failure. The dietitian was interviewed on 4/9/09 at 11:30 AM, and reported that she was aware that Resident #2 had been losing weight and that she had completed a dietary consult for the resident. She reported that she did not write any information on Resident #2's medical record, but that she routinely writes updates on the initial dietary evaluation record. She reported that she "must have missed this one." Review of the facility's nutrition policies and procedures revealed the following policy dated 2008, titled: "Subject: Referrals to the Registered Dietitian Procedures: 6. At his or her next facility visit, facility's registered dietitian (RD) will (a) complete the nutritional assessment or (b) document his her agreement with the Nutrition Services Director's review of the patient/resident status and indicate additional recommendations as appropriate." Review of "The Renal Network, Inc., Delivery of Dialysis Care Within the Long Term Care Facility, End Stage Renal Disease Special Study," dated 6/30/06, revealed the following industry standards: (Page 15) 4.4: "The Technical Expert Panel recommended the initial comprehensive assessment be completed within two weeks of admission to the unit, and reassessment every	F 325		

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F 325	Continued From page 19 month thereafter due to the short length of stay of many patients and their high level of acuity." Review of "Nutrition and Diagnosis Related Care," Lippincott Sixth Edition, Copyright 2008, revealed the following industry standards: "Table 16-13 Role of the Dietitian in Care of Dialysis Patients Multiple diet parameters are necessary to provide optimal nutritional health, including monitoring of calories, protein, sodium, fluid, potassium, calcium, and phosphorus, as well as other individualized nutrients. Consider all modes of nutritional intervention; use that which is best accepted by the patient and the least invasive. Peritoneal Dialysis -"Fluid restrictions are not always needed with peritoneal dialysis. Patient should learn how to recognize significant changes in dry weight (adjusted edema-free body weight) or food intake. Discuss actions to be taken. Usually, three to four pounds between intermittent peritoneal dialysis is allowed." Complaint #21850	F 325		
F 441 SS=G	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and	F 441	**F 441 Infection Control** Resident # 1 and # 2 have been discharged from the facility. Residents residing in the facility that receive peritoneal dialysis have the potential to be affected.	5-22-09

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F 441	Continued From page 20 corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on interview, record review, policy and procedure review, and industry standards, the facility failed to prevent the development and transmission of disease and infection related to peritoneal dialysis for 2 of 7 sampled residents (#2, #3). Findings include: Resident #2 Resident #2 was admitted to the facility on 1/15/09, with diagnoses including end stage renal disease, failure to thrive, coronary atherosclerosis, congestive heart failure, atrial fibrillation, anemia, and hypothyroidism. The resident's legal representative had been performing peritoneal dialysis for the resident in the community for six years, without the resident contracting an infection. Record review revealed a Minimum Data Set resident assessment for Resident #2: Section B., 4. Cognitive skills for daily decision making, dated 1/22/09, that showed that the resident had been independent in decision making with "decisions being consistent/reasonable." Record review revealed a weekly nursing summary dated 1/22/09, with the following boxes checked: "Alert, memory recall - current season, staff names/faces, that he was in a nursing home; decision making - independent." A weekly nursing summary dated 1/28/09, read: "Alert,	F 441	The measures in place are as follows: Re-educated Nursing staff on the policy and procedure on peritoneal dialysis on 4/16/09 by Director of Education. Licensed Nursing staff will have competency skills checklist on connecting and disconnecting CAPD residents from treatment and policy on appropriate method and time of using gloves by Director of Education/designee . Chart of a resident receiving peritoneal dialysis will be scrubbed by Director of Nursing/designee for completeness of documentation within 24 hours of admission and ongoing. ① Effective date of compliance is 5/22/09 per interview with Mailey Larson on 6/1/09 with Judith Whitts III ② "Scrubbed" means "will be thoroughly reviewed within 24 hours."	

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F 441	Continued From page 21 memory recall - staff names/ faces, that he is in a nursing home; decision making - independent." Record review revealed a physician's progress note dated 1/19/09 that read: "Abdomen: normal, peritoneal catheter." Record review revealed that Resident #2 had been transferred to an acute care facility on 3/7/09, for coughing and hypoxia. On 4/6/09 at 10:30 AM, Resident #2's son-in-law was interviewed and reported that a nurse from the facility contacted him on 3/6/09 at 8:00 AM, to notify him that the resident was coughing and refusing to take his medications. The son-in-law reported that the resident had become progressively worse overnight, with an oxygen saturation of 74% and the nurse had called again in the morning on 3/7/09. He reported that the nurse had stated to him that the resident's condition had deteriorated and that the nurse had asked him if he would like her to send him to the hospital. The resident's son-in-law then reported that he directed the nurse to call the nephrologist that follows the resident for treatment of his renal failure. He then reported that the nurse was not aware that the resident had a nephrologist involved with the resident's care. The nurse then agreed to call the nephrologist. The resident's son-in-law further reported that the nurse called him to report that she was directed by the nephrologist to send the resident to an acute care facility emergency department. The nurse then reportedly called a dialysis nurse consultant to determine whether or not to send the resident to the hospital. The resident's son-in-law reported that the nurse then called back to ask what hospital to send the resident to, and the	F 441	Daily weights of residents on CAPD will be reported to the Director of Nursing/designee and dietician/designee to address weight changes per policy and procedures on weight management. In addition nephrologist and dialysis dietician will be notified for collaborative approach on weight management. The Nursing Assessment Coordinator will be responsible to oversee that care plans reflect the care provided for each CAPD resident. Staff will be re-educated on proper hand washing techniques with return demonstration by Director of Education/designee. Peritoneal residents care status will be reviewed in the monthly Quality of Care meeting and reported during monthly Performance Improvement meetings. The Director of Nursing or designee will monitor this process on an ongoing basis.	

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F 441	Continued From page 22 son-in-law reported that he told her to send the resident to the closest hospital. The resident reportedly passed away on 3/11/09. Record review revealed a death certificate that reported that the resident had expired and that the cause of death was peritonitis. Review of Resident #2's medical record revealed entries made into the nurse's notes that contained the following: 2/25/09 - the psychiatrist did a consult with the resident and documented that the resident was "underhydrated?" 2/26/09 - "Patient continues to not eat takes some fluids... Increased apical rate, abdominal distension..." 2/27/09 - "the resident had an elevated temperature" 3/6/09 - "Resident agitated; resident coughing, chest x-ray ordered to rule out pneumonia; weight loss 31 pounds" 3/7/09 - "Resident agitated, yelling for help; alert and oriented to self, skin pale; breathing labored and oxygen saturation 74%; skin ash color with labored breathing; sent to emergency room for evaluation." No evidence was found that the nursing staff had contacted the physician related to a change in Resident #2's condition prior to 3/7/09. No evidence was found that the resident's primary physician had been aware of the psychiatrist's impression on 2/25/09. Record review revealed a care plan for Resident #2 that was developed for outpatient dialysis therapy. The care plan revealed the following: "Goals: will not experience complications secondary to dialysis for 90 days.	F 441		

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F 441	Continued From page 23 Approach: 1. Resident will be transported to dialysis center on treatment days. 2. Resident will be provided with take out meals if not in the facility at mealtimes. 3. Avoid taking blood pressures or giving injections over shunted arm. 5. After dialysis treatment observe resident for adverse reactions to treatment." Record review revealed that Resident #2 had no shunt, was not transported out, as his peritoneal dialysis was performed at the facility. Resident #3 Resident #3 was admitted to the facility on 3/18/09, with diagnoses including end-stage renal disease requiring peritoneal dialysis, diabetes mellitus and peripheral vascular disease. The resident was dependent for all peritoneal dialysis needs. Record review revealed a document titled "Nursing Assessment" that was completed upon Resident #3's admission on 3/18/09 that read: "Section 3. Vital Signs: temperature - 98.0 Fahrenheit Section 8. Physical Assessment: A. Neuro/Cognitive: independent in decision making with "decisions being consistent/reasonable." E. Pain: denies pain on admission J. Gastrointestinal: no problems documented" Record review revealed that Resident #3 had been transferred to an acute care facility on 4/4/09, with a temperature of 100.3 Fahrenheit.	F 441		

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F 441	Continued From page 24 Record review revealed the following nurse's notes entries: 3/23/09 - "Has disorientation at times." 3/24/09 - "Resident very needy, on the call light every 10 minutes." 3/25/09 - "Keeps on moaning, complains of shoulder pain." 3/28/09 - "Medicated for pain in left shoulder." 3/31/09 - "Resident difficult today. Not compliant. Found medications in his bed. Restless early shift. Calling for help constantly. Dialysis machine keeps beeping." Record review revealed the following: 3/24/09 night shift: temperature - 99.4 Fahrenheit 3/26/09 night shift: temperature - 99.1 Fahrenheit 4/4/09 night shift: temperature - 99.1 Fahrenheit Record review revealed the following entries into the physical therapy weekly summary: 3/20/09 - 3/26/09: "Patient has been ill intermittently...but puts effort towards his exercises ... throughout the day and tries his best without trying to regurgitate onto his caregivers." 3/27/09 - 4/2/09: "Actively participated in three of five treatments due to ... bilateral shoulder pain." Record review revealed no evidence that the physician had been made aware of Resident #3's condition changes prior to the day that the resident was transferred to the acute care facility. The Director of Nursing (DON) was interviewed on 4/9/09 at 11:20 AM, and reported that signs and symptoms to look for that may be indicative of peritonitis include: Distension or tenderness of the abdomen, nausea or vomiting, diarrhea, shoulder pain, elevated temperature, anxiety, change in level of consciousness, confusion, or	F 441		

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F 441	Continued From page 25 draining of cloudy dialysate. Record review of a physician's progress note dated 3/26/09, revealed: "had vomiting after therapy." The DON was interviewed on 4/9/09 at 11:20 AM, and reported that Resident #3 had been admitted to the acute care facility on 4/4/09, with a diagnosis of peritonitis. Review of Resident #3's acute care record revealed that on 4/5/09, the emergency department physician recorded: "Assessment: 1. Sepsis, source peritonitis versus health care associated pneumonia. Emergency Department Course: White blood cell count 14,000. X-ray was clear for pneumonia." Record review revealed that Resident #3 was still an inpatient at the acute care facility on 4/20/09. The Staff Development Coordinator was interviewed on 4/9/09 at 11:00 AM, and reported that almost all of the registered nurses (RNs) had completed training related to peritoneal dialysis. She reported that the facility had a consultant from a local dialysis center come in and train the facility staff related to peritoneal dialysis. Review of the dialysis consultant's training outline revealed that he recommended that staff not wear gloves throughout the peritoneal dialysis procedures. On 4/9/09 at 11:40 AM, the dialysis consultant was interviewed, and reported that he did	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 26	F 441		

recommend that staff not wear gloves during the peritoneal dialysis procedures because the powder in the gloves was a common source of peritonitis. When asked if the procedures were to be performed using aseptic technique, he replied "no, it is a clean procedure."

The DON reported that she performed the peritoneal dialysis procedures on week-days. She reported that she did not wear gloves while performing peritoneal dialysis procedures.

The Staff Development Coordinator was interviewed and reported that the nurses were instructed not to wear gloves because the powder inside of the gloves was a common cause of peritonitis.

Record review revealed no evidence that staff were wearing gloves while performing peritoneal dialysis procedures.

Review of the facility's policies and procedures revealed a policy and procedure dated 2004, titled: "Nursing Standards of practice, Subject: Dialysis, Peritoneal (CAPD)," indicated: "Standard:

1. The qualified nursing staff will provide care as ordered by a physician for patients/residents requiring peritoneal dialysis that allows them to maintain their highest practicable level of function and health.
2. The qualified nursing staff will follow the (corporate) guidelines.
3. The health care center will obtain the Resident Acknowledgement of Informed Consent Form #FFNP006
4. Refer to the Staff Development Standards of

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F 441	Continued From page 27 Practice: #24 Competency for Peritoneal Dialysis." "Description: Infection control practices and technique are essential to prevent the occurrence of peritonitis which often may prevent patients/residents from continuing to use peritoneal dialysis as a treatment modality. Staff who provide care must receive specialized training so they possess advanced skill levels before providing peritoneal dialysis. Equipment: C. sterile and non-sterile gloves Practice Guidelines: 5. Assess A. Weight: Baseline is needed to determine fluid to be removed. Dialysis Exchange: C. Wash hands, don mask and non-sterile gloves. Both licensed nurse and patient/resident mask. N. Don sterile gloves." Review of a peer review article published by the Mid-Atlantic Renal Coalition dated 12/02, titled: "Preventing Bacterial Infections and Antimicrobial Resistance in Dialysis Patients," revealed the following: "Strategy 4: Prevention -The Centers for Disease Control and Prevention (CDC) recommends wearing gloves at all times when touching patients or dialysis equipment to prevent infections by contaminants too small to	F 441		

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F 441	Continued From page 28 be seen with the naked eye." Complaint #21850	F 441		